

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01597

1620 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Nr. Westminster</u>		<u>44 Yrs.</u>		TOWN <u>Rural, Nr. Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Westminster, Md. R.D.1</u>				STREET ADDRESS (If rural give location) <u>Westminster, Md. R.D.1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Howard</u> (Middle) <u>Scott</u> (Last) <u>Bachman</u>				(Month) <u>2/9/56</u> (Day) <u>19</u> (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9/7/1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Day Laborer</u>		<u>All kinds work</u>		<u>Carroll Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Bachman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>219-12-0342</u>		<u>Mrs. Annie Bachman, Westminster, R.D.1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Pneumonia Broncho</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular Renal Disease</u>				<u>several</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>with myocardial degeneration</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis Seminal</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan 31</u> , 19 <u>56</u> , to <u>Feb 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 9</u> , 19 <u>56</u> , and that death occurred at <u>5:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William Speicher</u>				ADDRESS (Street, city, town, state) <u>Westminster Md</u> DATE SIGNED <u>Feb 10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/13/56</u>		<u>Kriders Cemetery</u>		<u>Nr. Westminster, Md. Carroll Co.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>2-11-56</u>		<u>H. Amet Miller</u>		<u>J. M. Little, Son, Littlestown, PA.</u>			
				<u>Per R. A. Little - Partner</u>			

MARYLAND

STATE DEPARTMENT OF HEALTH

1621 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ruth</u>	(Middle) <u>Ellen</u>	(Last) <u>Bair</u>
4. DATE OF DEATH	(Month) <u>2</u>	(Day) <u>4</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 4, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>35</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Bair</u>		14. MOTHER'S MAIDEN NAME <u>May Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>7-111-</u>	
17. INFORMANT AND ADDRESS <u>Father, Russell Bair, Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Coronary Occlusion</u>		<u>24 Hrs.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>34 Yrs.</u>
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1941, to Feb., 1956, that I last saw the deceased alive on Feb. 3, 1956, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE <u>M. Martin MD</u>	DATE <u>2/8/56</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>2-8-56</u>	REGISTRAR'S SIGNATURE <u>C. Harry Weber</u>	24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>	ADDRESS <u>Inc.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01599

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1622

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>5 mos.</u>		TOWN <u>Bethesda</u>		<u>15K-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>6411 Wilson Lane</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Rosa Henderson Baker</u>				<u>Feb. 9 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>9/6/1870</u>	<u>85</u> yrs.	Months <u>-</u>	Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Lewis</u>				<u>Jane Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>4-26</u>		<u>Hospital records.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>4200</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>				<u>years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Chronic Brain Syndrome associated with Cerebral arteriosclerosis with psychosis.</u>				<u>3 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/20/55</u>, 19....., to <u>2/9/56</u>, 19....., that I last saw the deceased alive on <u>2/9/56</u>, 19....., and that death occurred at <u>4:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				DATE SIGNED <u>2/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				ADDRESS (Street, city, town, state)			
<u>Burial</u>				<u>Sykesville, Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-10-56</u>		<u>C. Harry Weir</u>		<u>Robert A. Pennington</u>		<u>Bethesda, Md.</u>	

RECEIVED

1623
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 10/13/55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 16 W. Preston			
3. NAME OF DECEASED (Type or print) First Joseph Middle Edward Last BALLENGER				4. DATE OF DEATH Month February Day 28 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) yrs. 90	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction							INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 19 55 to 2-28- 19 56 , that I last saw the deceased alive on Febr. 28 , 19 56 , and that death occurred at 5:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward Lusthaus M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland			
DATE SIGNED 2/28/56							
PHYSICIAN'S NAME (Type) Edward Lusthaus							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-56		22c. NAME OF CEMETERY OR CREMATORY Randon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR DATE 3-29-56		24b. REGISTRAR'S SIGNATURE C. Harry Zwick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville		c. LENGTH OF STAY IN 1b 16Y, 5M, 27D	
d. NAME OF HOSPITAL (If not in hospital, give street address) 15 Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle M. Last BARLOW		4. DATE OF DEATH Month 2 Day 23 Year 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/91
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Flaherty		14. MOTHER'S MAIDEN NAME Anastasia Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meta/static carcinoma of bones 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the breast DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type		INTERVAL BETWEEN ONSET AND DEATH months 1 year +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/23 , 19 56 , to 2/23 , 19 56 , that I last saw the deceased alive on 2/23 , 19 56 and that death occurred at 9:27A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 2/23/56 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24. REC'D BY REGISTRAR 27 1956	
ADDRESS -3000 E. Baltimore Street		24b. REGISTRAR'S SIGNATURE Peter Barry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

01602

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 74

1625

1. PLACE OF DEATH- COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural - Sykesville				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural - Sykesville P.O.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100				STREET ADDRESS (If rural, give location) Florenceville			
3. NAME OF DECEASED (Type or Print)		(First) LLOYD		(Middle) F.		(Last) BEAVER	
4. DATE OF DEATH		(Month) 2		(Day) 20		(Year) 1956	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 4/ /02	
9. AGE last birthday		53 yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer				10b. KIND OF BUSINESS OR INDUSTRY Hospital			
13. FATHER'S NAME Granville Beaver				14. MOTHER'S MAIDEN NAME Margaret E. Reynolds			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none			
17. INFORMANT AND ADDRESS Miss Ida Mae Beaver - Sykesville, Md				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
976X Immediate cause (a) Gun shot wound of head						?	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY 2 20 56 6:30AM				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
HOW DID INJURY OCCUR? self-inflicted gun shot wound							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE James J. Thoren				ADDRESS Westminster, Maryland			
DATE SIGNED 2/21/56							
23. FUNERAL, CREMATION OR DISPOSAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Buried		2-24-56		Sykesville		Sykesville, Md.	
24. REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
Feb. 23/1956		C. Harry Weber		Arthur W. Hight		Sykesville, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 27 1956

BUREAU V. 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1626 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01603

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 y 9 mo 19 d</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>	
d. STREET ADDRESS <u>1802 Euta W Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Beavers</u> Last <u>Beavers</u>		4. DATE OF DEATH Month <u>Feb</u> - Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1870</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>NANCY FOX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk -</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile changes in the brain with psychosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May - 12 - 1954</u> , to <u>Feb - 26 - 1956</u> , that I last saw the deceased alive on <u>Feb - 26 - 1956</u> , and that death occurred at <u>2:03 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2-26-56</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	22d. LOCATION (City, town, or county) (State) <u>Bellicott City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u> ADDRESS <u>Catoxville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-28-56</u> 24b. REGISTRAR'S SIGNATURE <u>C. Harry Turner</u>	

BUREAU V. S.

FEB 29 1956

RECEIVED

1615

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>Union Bridge</u> X			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman E Bohn</u>				4. DATE OF DEATH Month Day Year <u>Feb 18 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1882</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>novelty</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Reuban Bohn</u>				14. MOTHER'S MAIDEN NAME <u>Susan Weant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-8900</u>		17. INFORMANT <u>Mrs. Norman E. Bohn</u>		Address <u>129 W. Main St Westminster</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.4</u> DUE TO <u>Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mos</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>56</u> , to <u>2-18-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-18-</u> , 19 <u>56</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge Md 2-20-56</u>			
PHYSICIAN'S NAME (Type) <u>T. H. Legg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brethren Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rocky Ridge Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Dumas</u>				ADDRESS <u>Taneytown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-21-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. Amitt Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5

5

0-1

273.00

 $\gamma_{\text{L}}^{\text{L}}$

5

 $\alpha = 0$

2. 2. 2.

2.

524, 91.

[illegible]

ကံ့ခိုက် အားလုံး

John R. R.

100-10-75

٢٢٢

N. C.

[Continued]

BUREAU V. S.

FEB 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1627

CERTIFICATE OF DEATH

01605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 2 mos. 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Springfield State Hospital				d. STREET ADDRESS 916 Webb Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEONARD DANIEL Middle BRADFIELD Last DEATH				4. DATE OF DEATH Month 2 Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/03		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Linton D. Bradfield				14. MOTHER'S MAIDEN NAME Ada Suit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-18-0291		17. INFORMANT Record, Springfield State Hospital, Sykesville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 527.1 IMMEDIATE CAUSE (a) Emphysema of the lung DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002x DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/14 , 19 55 , to 2/27 , 19 56 , that I last saw the deceased alive on 12/26 , 19 56 , and that death occurred at 6:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 2/27/56							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				22. NAME OF CEMETERY OR CREMATORY Baltimore Cem.			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt.				24a. REC'D BY REGISTRAR Feb 28 1956		24b. REGISTRAR'S SIGNATURE C. Harry	

CERTIFICATE OF DEATH

1892

1892

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Smith		Male		45		Jan. 10, 1892		City of Baltimore	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocarditis		Sudden		10:30 AM		Dr. J. H. Jones	
Occupation		Residence		Burial Place		Interment		Remarks	
Clerk		1234 Main St.		St. Paul's Church		Buried			
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
J. H. Jones		W. B. Smith		C. D. Brown		R. E. White		T. A. Green	

RECEIVED
FEB 29 1892
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01606

1628

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First John Middle J. Last Cavill		4. DATE OF DEATH Month Feb. Day 22 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1884
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Cavell		14. MOTHER'S MAIDEN NAME Ellen Donovan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Records of Springfield State Hospital		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis with Hypertension DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes more than 14 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Spt. 1 , 19 47 , to Feb. 22 , 19 56 , that I last saw the deceased alive on Feb. 21 , 19 56 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Martin Gross M.D. Sykesville, Md Feb. 22, 1956 PHYSICIAN'S NAME (Type) Martin Gross, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Dept. 1956		22b. DATE THEREOF Feb. 23 1956	
22c. NAME OF CEMETERY OR CREMATORY London Park Cem		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. M. Walters		24. REC'D BY REGISTRAR Feb 23 1956	
ADDRESS Seneca		25. REGISTRAR'S SIGNATURE C. Harry Heaps	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		30 yrs		1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Carpenter		Myocardial infarction		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
Feb 23, 1956		Home		1000		1000	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
J. H. Harris		J. H. Harris		Feb 23, 1956		Baltimore, Md.	

BUREAU V. 2

FEB 23 1956

RECEIVED

James H. Harris
1000
1000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01607

1616

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster		LENGTH OF STAY (in this place) 6 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 24 New Windsor Road		STREET ADDRESS (If rural give location) 24 New Windsor Road					
3. NAME OF DECEASED (Type or Print) Mary Elizabeth Dell				4. DATE OF DEATH (Month) Feb. (Day) 21 (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 28, 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Burns				14. MOTHER'S MAIDEN NAME Margaret Dittman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS Mrs. N.B. Buckingham Westminster, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) Carcinoma of lungs				INTERVAL BETWEEN ONSET AND DEATH 10 months			
ANTECEDENT CAUSE(S) DUE TO (B) Chr. Myocarditis				5 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1956</u>, to <u>Feb 21, 1956</u>, that I last saw the deceased alive on <u>Feb 21, 1956</u>, and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <i>Shepherd Barr</i> M.D.				ADDRESS (Street, city, town, state) <i>Westminster, Md</i>		DATE SIGNED <i>2/22/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 24, 56		NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		LOCATION (City, town, or county) (State) Gamber, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Hansel Muller</i>		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.		ADDRESS	
DATE <i>2-23-56</i>							

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

Form No. 10

LOCAL HEALTH DEPARTMENT OF DEATH

City of Boston

DEATH OF

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF BURIAL

NAME OF DECEASED

NAME OF DECEASED

BUREAU V. B.

FEB 27 1956

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 01608

1629 CERTIFICATE OF DEATH

Reg. Dist. No. ³⁴304

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Sykesville		5 years, 2 mths		TOWN Hancock		21X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital.				STREET ADDRESS (If rural give location) Hancock, Maryland			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Edward (Middle) Theodore (Last) Ditto				(Month) 2-- (Day) 17 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	8-7-18	37 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Edward Ditto				14. MOTHER'S MAIDEN NAME Daisy Ray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Florence Little, aunt 230 Market St., Frederick, Md.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
454X IMMEDIATE CAUSE (A) Gangrene of the small intestine						days	
DUE TO ANTECEDENT CAUSE(S) (B) Mesenteric thrombosis						days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Psychoneurosis-Anxiety hysteria						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-15- , 19 50 , to 2-17 , 19 56 , that I last saw the deceased alive on 2-17- , 19 56 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
SIGNATURE Walther H. Lomenfeldt				ADDRESS (Street, city, town, state) Springfield State Hospital		DATE SIGNED 2-18-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		2-21-56		Presbyterian Cemetery		Washington, D.C.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
2/20/56		W. H. Lomenfeldt		Howard J. Stone Hancock, Md.			

1922 CERTIFICATE OF DEATH

Birth Date

Place of Birth

County

Age

Sex

Color

Married

Occupation

Cause of Death

Immediate Cause

Date

Time

Place

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

Age

Sex

Color

Signature

BUREAU V. 2

FEB 21 1922

RECEIVED

1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01609

1630

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
CITY OR TOWN <u>Rural Westminster</u>		LENGTH OF STAY (in this place) <u>3 yrs</u>		STREET ADDRESS <u>26 Charles St.</u>		STREET ADDRESS <u>26 Charles St.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>DYKES</u> (Last)				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>14</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>?</u>	9. AGE last birthday <u>71?</u> yrs.	IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u>		IF UNDER 24 HRS. Hours <u>?</u> Min. <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>
13. FATHER'S NAME <u>John Dykes</u>				14. MOTHER'S MAIDEN NAME <u>Mary?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S ADDRESS <u>26 Charles St. Rural Westminster Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422. IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular Disease</u>				<u>16 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Had a crushed spine several years ago</u>							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Head hit</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Don't know</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1940 (?)</u> M. <u></u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>a tractor saved me</u>			
22. I hereby certify that I attended the deceased from <u>1949</u> , 19 <u>1949</u> , to <u>Feb 14</u> , 19 <u>1956</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>1956</u> , and that death occurred at <u>9 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>V. C. Stone</u>				DATE SIGNED <u>Feb 14 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Ellenorth Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>	
24. REC'D BY REGISTRAR <u></u>		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Myers, Jr.</u>		ADDRESS <u>Westminster Md.</u>	
DATE <u>2-16-56</u>							

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01610

1631 CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Taneytown</u>		LENGTH OF STAY (in this place) <u>65 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Taneytown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Fairview Avenue</u>				STREET ADDRESS (If rural give location) <u>15 Fairview Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Rosa</u> (First) <u>B.</u> (Middle) <u>Eckard</u> (Last)				4. DATE OF DEATH (Month) <u>2/10/56</u> (Day) <u>19</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/27/1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Housewife, Housework</u>)			10b. KIND OF BUSINESS OR INDUSTRY <u>Her own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Andrew J. Ohler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Fleagle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-2141</u>		17. INFORMANT & ADDRESS <u>Clarence L. Eckard, Taneytown, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331x IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>53 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral arteriosclerosis and hypertension</u>						<u>on 5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic myocarditis</u>						<u>10 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 11</u> , 19 <u>40</u> , to <u>Feb. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 9</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> <u>A</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. S. McVaugh</u>				DATE SIGNED <u>2/10/56</u>			
ADDRESS (Street, city, town, state) <u>49 Frederick St. Taneytown, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Taneytown, Carroll Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Feb 11, 1956</u>		REGISTRAR'S SIGNATURE <u>Ethel M. Wehring</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Little, Son</u>		ADDRESS <u>Littlestown, Pa.</u>	
<u>Local P. R. A. Little - Partner</u>							

RECEIVED

1632 CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westminster</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		STREET ADDRESS (If rural give location) <u>57 Ralph St.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>W</u>	(Middle) <u>DONALD</u>	(Last) <u>ECKER</u>	DATE OF DEATH: <u>Feb. 2</u> 19 <u>56</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. B. DATE OF BIRTH: <u>1/21/1905</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>auto</u>	9. AGE last birthday <u>51</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Charles Y. Ecker</u>		14. MOTHER'S MAIDEN NAME: <u>Jessie Slater</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY No. <u>214-03-5766</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Marcie S. Ecker, Westminster Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE			
(A) <u>Coronary Occlusion</u>			3 hours
ANTECEDENT CAUSE (S)			
(B) <u>Coronary sclerosis & insufficiency</u>			- several months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 15, 1956</u> , to <u>Feb 2, 1956</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>56</u> , and that death occurred at <u>9:38</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>2/4/56</u>	
ADDRESS <u>Westminster Md</u>		M. D. <u>Westminster Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/5/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cem. Westminster Md</u>		LOCATION (City, town, or county) (State) <u>Westminster Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-4-56</u>		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	
24. FUNERAL DIRECTOR <u>D. W. Hartgering</u>		ADDRESS <u>1000 S. ...</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete form filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01612

1633

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 yrs & 2 mths			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital.				d. STREET ADDRESS Route 1			
3. NAME OF DECEASED (Type or print) First Warren Middle Brent Last Ellis				4. DATE OF DEATH Month 2 Day 25 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?		9. AGE (In years last birthday) 75 ? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Simon J. Haines (brother in law)			
				Address Route # 1 Gaithersburg Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis heart disease Chronic brain syndrome with senile brain disease with psychotic reactions-Chronic hepatitis							INTERVAL BETWEEN ONSET AND DEATH days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-23-1952 , to 2-25-1956 , that I last saw the deceased alive on 2-25-1956 , and that death occurred at 9.15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 2-25-56							
ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital. 2-25-56							
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.							
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF FEB 28		22c. NAME OF CEMETERY OR CREMATORY Laytonsville Cem.		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H Barber, Laytonsville Md.				24a. REC'D BY REGISTRAR DATE 2-28-56		24b. REGISTRAR'S SIGNATURE C. Henry Talon	

1522

— 22 —

•

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

FEB 29 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01613

1634

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hampstead</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hampstead</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>JOSHUA - L - ENSOR</i>		4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>15</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec 3 - 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harbor</i>	9. AGE last birthday <i>78</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>CAGEY - ENSOR</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-32-4006</i>	
17. INFORMANT & ADDRESS <i>Clarence Ensor, Hampstead Md</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
420.1 IMMEDIATE CAUSE (A) <i>Myocardial Infarction</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Thrombosis</i>			<i>1 day</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1-20-56</i> , to <i>2-15-56</i> , that I last saw the deceased alive on <i>2-14-56</i> , and that death occurred at <i>8:30</i> M., from the causes and on the date stated above.			
SIGNATURE <i>M. C. Porter</i>		DATE SIGNED <i>2-16-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	
DATE THEREOF <i>Feb 18/56</i>		LOCATION (City, town, or county) <i>Carroll Co Md</i>	
24. REC'D BY REGISTRAR <i>Henry J. Bell</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E. Tipton</i>	
REGISTRAR'S SIGNATURE		ADDRESS <i>Hampstead Md</i>	
DATE <i>2/16/56</i>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01614

1635 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Sykesville</u>		<u>10 yrs. 5 mos.</u>		TOWN <u>Baltimore</u>		<u>3 Vol. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Anna</u>		(Middle) <u>Fazenbaker</u>		(Last)			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov. 22, 1895</u>	
				9. AGE last birthday <u>60</u> yrs.		IF UNDER 1 YEAR (Month) (Day) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Condry</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Keiscrote</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Manic Reaction in an alcoholic setting.</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1 - 1956</u> , to <u>2 - 8, 1956</u> , that I last saw the deceased alive on <u>2 - 7 - 1956</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur H. Somerville</u> M.D.				DATE SIGNED <u>2/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
24. REC'D BY REGISTRAR <u>2-10-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u>			

FEB 15 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1636

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg 15-X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LORENZO Middle LEE Last FINK				4. DATE OF DEATH Month 2/ Day 22 Year 1956			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/81		9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Micael Fink				14. MOTHER'S MAIDEN NAME Martha Cullers Fink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - Used		17. INFORMANT Address Record, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 56 , to 2/22 , 19 56 , that I last saw the deceased alive on 2/22 , 19 56 , and that death occurred at 1:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 2/22/56	
PHYSICIAN'S NAME (Type) Edmund Lusthaus							
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/25/56		St. Luke's Cemetery		Redland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber, Laytonville				24a. REC'D BY REGISTRAR DATE 2-28-56		24b. REGISTRAR'S SIGNATURE C. Harry Trew	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
FEB 29 1956		BALTIMORE, MARYLAND		NATURAL	
AGE		SEX		RACE	
38		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 15 1918		BALTIMORE, MARYLAND		HIGH SCHOOL	
OCCUPATION		MARITAL STATUS		RELIGION	
LABORER		MARRIED		CATHOLIC	
PREVIOUS ILLNESS		CAUSE OF DEATH		IMMEDIATE CAUSE	
NONE		HEART DISEASE		CORONARY ARTERY DISEASE	
SYMPTOMS		SIGNS		TESTS	
Chest pain, shortness of breath		Tachycardia, hypertension		ECG, chest X-ray	
Duration of illness		Time of death		Time of autopsy	
2 days		FEB 29 1956		FEB 29 1956	
Physician's signature		Medical examiner's signature		Registrar's signature	
[Signature]		[Signature]		[Signature]	

BUREAU V. 3
RECEIVED
FEB 29 1956

1637 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Allegheny</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Sykesville</i>		LENGTH OF STAY (in this place) <i>30y 10mo.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		<i>01-22-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <i>Edith</i> (Middle) (Last) <i>Fingel</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>2-12-1956</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>		8. DATE OF BIRTH: <i>2 April 1902</i>	
9. AGE last birthday: <i>53</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>none</i>			
13. FATHER'S NAME: <i>Patrick Fingel</i>				14. MOTHER'S MAIDEN NAME: <i>Jane Burkley</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>unk -</i>		17. INFORMANT & ADDRESS: <i>Hospital records</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Septicemia</i>						<i>weeks.</i>	
ANTECEDENT CAUSE (B) <i>Orbital gangrene</i>						<i>weeks.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>903.7</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture of left femur. Schizophrrenic reaction tuberculous type</i>						<i>2mo 19 days 31y +</i>	
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>hospital ward</i>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>Springfield State Hospital Md.</i>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11. 24.55 M.</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <i>fell running across the day-hall</i>			
22. I hereby certify that I attended the deceased from <i>11-25</i> , 1956, to <i>2-12</i> , 1956, that I last saw the deceased alive on <i>2-11</i> , 1956, and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walker H. Sonnenfeldt</i>		ADDRESS <i>Springfield State Hospital</i>		DATE SIGNED <i>2/28/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-15-56</i>		NAME OF CEMETERY OR CREMATORY <i>St. Patricks</i>		LOCATION (City, town, or county) (State) <i>Cumberland Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-12-56</i>		REGISTRAR'S SIGNATURE <i>C. Harry Allen</i>		24. FUNERAL DIRECTOR <i>John D. Hefner</i>		ADDRESS <i>Cumberland Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1638 CERTIFICATE OF DEATH

01617

70

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Taneytown</u>		<u>Life</u>		TOWN <u>Rural Taneytown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Franklin</u> (Middle) <u>Motter</u> (Last) <u>Forney</u>				Feb. 13, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Single</u>	<u>Nov. 14, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Own Farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James J. Forney</u>				<u>Eleanor Stambaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>217-12-2000</u>		<u>Miss Macie Forney, Taneytown, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Artery Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>6 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>5 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>						<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 16, 1946</u> , to <u>Feb. 13, 1956</u> , that I last saw the deceased alive on <u>Feb. 9, 1956</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. D. McVaugh</u>				DATE SIGNED <u>Feb. 15, 1956</u>			
ADDRESS (Street, city, town, state) <u>M.D. 49 Frederick St. Taneytown, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 16, 1956</u>		<u>Keysville Cemetery</u>		<u>Keysville, Carroll, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 15/1956</u>		<u>Ethel M Mehring</u>		<u>C. O. Fessenden</u>		<u>Taneytown Maryland</u>	
DATE							

Locall

1938 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 10

01815

THIS DAY OF

LOCAL RESIDENCE AND PLACE OF DEATH

LAST RESIDENCE

MASSACHUSETTS

COUNTY

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

BUREAU V. S.

FEB 17 1936

RECEIVED

CO. 1st Inf. Regt. 1st Div.

1639

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville				c. LENGTH OF STAY IN lb Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				d. STREET ADDRESS Berrett			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RIDGLEY Middle GARHEART Last GARHEART				4. DATE OF DEATH Month FEB. Day 26 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1891	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William I. Garheart				14. MOTHER'S MAIDEN NAME Rachel A. Penn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Guy R. Garheart, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial hypertrophy and dilatation DUE TO (c) hypertensive cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH 48 hrs 10 yrs. 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1940 , 19____, to 26 February, 1956 , that I last saw the deceased alive on 25 February, 1956 , and that death occurred at 1:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road, Sykesville P.O., Md. DATE SIGNED 2.26.56							
ACTUAL SIGNATURE Wm. H. Lawson, Jr.				PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-29-1956		22c. NAME OF CEMETERY OR CREMATORY Brandenburg		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Lawson, Jr.				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE Feb. 29 1956	
				24b. REGISTRAR'S SIGNATURE Robert R. Hewitt			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE (Print or Write)		SEX MALE FEMALE	
AGE YEARS MONTHS DAYS (Print or Write)		DATE OF BIRTH YEAR MONTH DAY (Print or Write)	
PLACE OF BIRTH (Print or Write)		PLACE OF DEATH (Print or Write)	
OCCUPATION (Print or Write)		CAUSE OF DEATH (Print or Write)	
MANNER OF DEATH (Print or Write)		MEDICAL ATTENDANT (Print or Write)	
SIGNATURE OF DECEASED (Print or Write)		SIGNATURE OF MEDICAL ATTENDANT (Print or Write)	
SIGNATURE OF NEXT OF KIN (Print or Write)		SIGNATURE OF REGISTRAR (Print or Write)	
DATE OF DEATH YEAR MONTH DAY (Print or Write)		TIME OF DEATH (Print or Write)	
PLACE OF INTERMENT (Print or Write)		NAME OF FUNERAL HOME (Print or Write)	
SIGNATURE OF FUNERAL HOME (Print or Write)		SIGNATURE OF REGISTRAR (Print or Write)	

BUREAU V. S.

MAR 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01619

1640 CERTIFICATE OF DEATH

Item 8, Film G102 2-20-56 et

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN rural Westminster		LENGTH OF STAY (in this place) 5 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN rural Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glover's Nursing Home				STREET ADDRESS R 4 (If rural give location) Reese			
3. NAME OF DECEASED (First) Ida (Middle) ----- (Last) Green				4. DATE OF DEATH (Month) Feb. (Day) 11 (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 2, 1869 1860	9. AGE last birthday 95 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Green				14. MOTHER'S MAIDEN NAME Mary Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS Mrs. John L. Magee Westminster, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebrovascular Accident						INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Inter-arterio-sclerotic Cerebrovascular Disease						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1955, to 2/11 1956, that I last saw the deceased alive on 2/11 1956, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE J. Allen Moulton		M.D. 148 Wm. St. Westminster Md		DATE SIGNED 2/13/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 14, 1956		NAME OF CEMETERY OR CREMATOR Sandymount Cemetery		LOCATION (City, town, or county) Sandymount, Maryland	
24. REC'D BY REGISTRAR DATE 2-14-56		REGISTRAR'S SIGNATURE Harold Muller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	

CERTIFICATE OF DEATH

Dec. 31, 1955

DECEASED'S NAME (Last, first, middle initial)

County of

DATE OF BIRTH (Month, day, year)

PLACE OF BIRTH (City, town, village, or foreign country)

DATE OF DEATH (Month, day, year)

PLACE OF DEATH (City, town, village, or foreign country)

CAUSE OF DEATH (Immediate cause)

CAUSE OF DEATH (Underlying cause)

CAUSE OF DEATH (Contributing cause)

CAUSE OF DEATH (Manner of death)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

CAUSE OF DEATH (Other cause)

BUREAU V. S.

FEB 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01620

1641

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--Sykesville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--Sykesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>Gist</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DAVID</u>		(Middle) <u>G.</u>		(Last) <u>GRIMES</u>		(Month) <u>FEB.</u> (Day) <u>10.</u> (Year) <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>9-30-1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Bellison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Katherine Grimes, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>443X</u> <u>Coronary collapse - acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertensive cardiovascular disease with arteriosclerosis</u>						<u>15-20 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>senility & senile changes</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1935</u> , 19....., to <u>10 Feb</u> , 19....., that I last saw the deceased alive on <u>10 Feb</u> , 19....., and that death occurred at <u>2:45 P</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>2-13-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>Robert P. Hewitt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Maryland</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND, BALTIMORE

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]

EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]

PREVIOUS ILLNESS: [illegible]
TREATMENT: [illegible]
HISTORY: [illegible]

TESTIMONY: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TESTIMONY: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TESTIMONY: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. B.

FEB 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G193 3-7-56 et

1642

CERTIFICATE OF DEATH

Reg. Dist. No.

01621
10

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Taneytown, Md.		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, nr. Taneytown, Md.		d. STREET ADDRESS Uniontown District	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Bridge, Md. R-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle V. M. Last Hankey		4. DATE OF DEATH Month 2/25/56 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/25/1882
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework, Housewife		10b. KIND OF BUSINESS OR INDUSTRY Her own home	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Harner		14. MOTHER'S MAIDEN NAME Lydia Ann Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Denton E. Powell		Address Denton E. Powell, R.D.1, Union Bridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration 422.1 DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adema ulcers of foot		INTERVAL BETWEEN ONSET AND DEATH 4 mos 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II as item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956 to Feb 25, 1956 and that death occurred at 11:05 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Uniontown, Md. DATE SIGNED Feb 26, 1956	
ACTUAL SIGNATURE R F Reese Wilkens		PHYSICIAN'S NAME (Type) R F Reese Wilkens	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/56	
22c. NAME OF CEMETERY OR CREMATORY Grace Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G M Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR MA		24b. REGISTRAR'S SIGNATURE Mr. Earl McHenry	
DATE 1956		24c. REGISTRAR'S SIGNATURE Mrs. Margaret Engler	

1643

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>18y10m 7d</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frederick</u>	<u>10-11-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Katherine</u>	(Middle) <u>Hardey</u>	OF DEATH: <u>2</u> <u>19</u> <u>1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>8-29-1869</u>
9. AGE last birthday <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Dr. Thos. E. Hardey</u>		14. MOTHER'S MAIDEN NAME: <u>Katherine Wiener</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>170X Carcinoma of Breast with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE (S) <u>DUE TO</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DUE TO</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Senile Psychosis depressed type</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-18-1955</u> , to <u>2-19-1956</u> , that I last saw the deceased alive on <u>2-18-1956</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edna and Susthaus</u>		DATE SIGNED <u>2-19-1956</u>	
ADDRESS <u>Sykesville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-22-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-21-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Wiener</u>	
24. FUNERAL DIRECTOR <u>C. E. Cline & Son</u>		ADDRESS <u>Frederick, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1956
BUREAU V. 2

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01623

1644 **CERTIFICATE OF DEATH**Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>16 days</u>		TOWN <u>Baltimore-2</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1719 Hope Street</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY ELLEN HARVEY</u>				<u>2 17 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>W</u>	<u>Separated</u>	<u>5/31/75</u>	<u>80</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>at home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Patrick McNally</u>				14. MOTHER'S MAIDEN NAME <u>Mary McKivitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
416X IMMEDIATE CAUSE (A) <u>Chronic Rheumatic Heart Disease</u>						<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Infarction of the left lung</u>						<u>1 week</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/31</u> , 19 <u>56</u> , to <u>2/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>56</u> , and that death occurred at <u>8:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/17/56</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/20/56</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore,</u>		<u>Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 18, 1956</u>	REGISTRAR'S SIGNATURE <u>C. Harry Dean</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>			

1964 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

01023

REG. NO. 100-100

1. DECEASED PERSON'S NAME (Last, first, middle initial)

2. PLACE OF BIRTH

3. SEX

4. DATE OF BIRTH

5. AGE

6. RACE

7. MARRIAGE

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. DATE OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERGY

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL PLACE

19. SIGNATURE OF INTERMENT

20. SIGNATURE OF RECORDS

21. SIGNATURE OF VITALS

22. SIGNATURE OF DEATH

23. SIGNATURE OF BIRTH

24. SIGNATURE OF MARRIAGE

25. SIGNATURE OF DIVORCE

26. SIGNATURE OF WILLS

27. SIGNATURE OF PROBATE

28. SIGNATURE OF ESTATE

29. SIGNATURE OF TRUST

30. SIGNATURE OF POWER

31. SIGNATURE OF ATTORNEY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF RECTOR

35. SIGNATURE OF DEACON

36. SIGNATURE OF CHURCH

37. SIGNATURE OF MINISTRY

38. SIGNATURE OF SACRAMENT

39. SIGNATURE OF BAPTISM

40. SIGNATURE OF CONFIRMATION

41. SIGNATURE OF EUCARIST

42. SIGNATURE OF ANOINTING

43. SIGNATURE OF EXORCISM

44. SIGNATURE OF BLESSING

45. SIGNATURE OF CONSECRATION

46. SIGNATURE OF SACRILEGE

47. SIGNATURE OF SIMONY

48. SIGNATURE OF HERESY

49. SIGNATURE OF APOSTASY

50. SIGNATURE OF SCHISM

51. SIGNATURE OF EXCOMMUNICATION

52. SIGNATURE OF INTERDICTION

53. SIGNATURE OF SACERDOTAL

54. SIGNATURE OF BISHOPRIC

55. SIGNATURE OF ARCHBISHOPRIC

56. SIGNATURE OF PAPAL

57. SIGNATURE OF VATICAN

58. SIGNATURE OF ROMAN

59. SIGNATURE OF CATHOLIC

60. SIGNATURE OF CHURCH

61. SIGNATURE OF DEATH

62. SIGNATURE OF BIRTH

63. SIGNATURE OF MARRIAGE

64. SIGNATURE OF DIVORCE

65. SIGNATURE OF WILLS

66. SIGNATURE OF PROBATE

67. SIGNATURE OF ESTATE

68. SIGNATURE OF TRUST

69. SIGNATURE OF POWER

70. SIGNATURE OF ATTORNEY

71. SIGNATURE OF JUDGE

72. SIGNATURE OF CLERK

73. SIGNATURE OF RECTOR

74. SIGNATURE OF DEACON

75. SIGNATURE OF CHURCH

76. SIGNATURE OF MINISTRY

77. SIGNATURE OF SACRAMENT

78. SIGNATURE OF BAPTISM

79. SIGNATURE OF CONFIRMATION

80. SIGNATURE OF EUCARIST

81. SIGNATURE OF ANOINTING

82. SIGNATURE OF EXORCISM

83. SIGNATURE OF BLESSING

84. SIGNATURE OF CONSECRATION

85. SIGNATURE OF SACRILEGE

86. SIGNATURE OF SIMONY

87. SIGNATURE OF HERESY

88. SIGNATURE OF APOSTASY

89. SIGNATURE OF SCHISM

90. SIGNATURE OF EXCOMMUNICATION

91. SIGNATURE OF INTERDICTION

92. SIGNATURE OF SACERDOTAL

93. SIGNATURE OF BISHOPRIC

94. SIGNATURE OF ARCHBISHOPRIC

95. SIGNATURE OF PAPAL

96. SIGNATURE OF VATICAN

97. SIGNATURE OF ROMAN

98. SIGNATURE OF CATHOLIC

99. SIGNATURE OF CHURCH

100. SIGNATURE OF DEATH

BUREAU V. 1

FEB 23 1956

RECEIVED

1645

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) 15 Springfield State Hospital				e. STREET ADDRESS 828 N. Linwood Avenue, Balto			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET HIDDEN				4. DATE OF DEATH Month Day Year 2 22 56			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/73		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Fred Miller				14. MOTHER'S MAIDEN NAME Martha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Record, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 - 4 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome due to cerebral arteriosclerosis, with psychosis YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/7 , 19 56 , to 2/22 , 19 56 , that I last saw the deceased alive on 2/22 , 19 56 , and that death occurred at 10:26 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sykesville, Maryland 2/22/56 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-56		22c. NAME OF CEMETERY OR CREMATOR Oakwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Cox, Inc.				24a. REC'D BY REGISTRAR DATE 2-25-56		24b. REGISTRAR'S SIGNATURE C. Harry Weir	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

FEB 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01625

CERTIFICATE OF DEATH

1646

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>2Y, 7M, 2 days</u>		TOWN <u>RFD, Hagerstown</u>		TOWN <u>21X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALICE</u> <u>HOOVER</u>				<u>2</u> <u>3</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/21/69</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 Year		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Eyhran Hammersla</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Rowland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>John A. Hoover</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombosis of iliac vein, right</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CBS associated with senile brain disease, with psychotic reaction</u>						<u>3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/16/56</u> , 19 <u>56</u> , to <u>2/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>56</u> , and that death occurred at <u>8:20A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sommerfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. REC'D BY REGISTRAR <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>C. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

01626

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

70

: 1647

USE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Littletown Pa.</u>		STATE <u>Md</u> COUNTY <u>Carroll</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>just across Md-Pa line</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Carroll - Littletown Pa</u>	
3. NAME OF DECEASED (Type or Print) <u>KECKLER, ROBERT SCHLEY</u>		4. DATE OF DEATH <u>Feb. 17 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 6, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Computer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>DAVID A KECKLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY DENTLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>		17. INFORMANT AND ADDRESS <u>Jason C. Souders Emmitsburg Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary artery disease</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE James J. Marsh, Deputy Medical Examiner - Westminster Md ADDRESS Emmitsburg Md DATE SIGNED Feb 19/56

23. FINAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>Feb 20, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>MT-VIEW</u>	LOCATION (City, town, or county) (State) <u>EMMITSBURG MD.</u>
DATE REC'D BY LOCAL REG. <u>Feb 18, 1956</u>	REGISTRAR'S SIGNATURE <u>Ethel M. Mahring</u>	24. FUNERAL DIRECTOR <u>S. L. Allison</u>	ADDRESS <u>EMMITSBURG MD.</u>

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 21 1952

BUREAU V. S.

1648

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Ma</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i> <i>3701-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>15 Springfield Hall Hospital</i>				STREET ADDRESS (If rural give location) <i>39 W. Preston St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>ELIZABETH W. KUHN</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>2-17 1956</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>Wh</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>10-13-1868</i>	9. AGE last birthday <i>87</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Welder</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>factory</i>		11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Thomas Capes</i>				14. MOTHER'S MAIDEN NAME: <i>Bettie Blackstone</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No. <i>unusual</i>		17. INFORMANT & ADDRESS: <i>Hospital Records</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
527.1 IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>						<i>few days</i>	
ANTECEDENT CAUSE (S) DUE TO <i>Pulmonary emphysema</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Schizophrenia, paranoid type since 1914</i>							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2-17 1956</i> , to <i>2-17 1956</i> , that I last saw the deceased alive on <i>2-17 1956</i> , and that death occurred at <i>10:00 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Julian Rudykewycz</i>		ADDRESS <i>Julian Rudykewycz</i>		DATE SIGNED <i>2-17-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>2-20-56</i>		NAME OF CEMETERY OR CREMATORY <i>Western Cem.</i>		LOCATION (City, town, or county) (State) <i>Balta Cem</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-18-56</i>		REGISTRAR'S SIGNATURE <i>C. Harry Egan</i>		24. FUNERAL DIRECTOR ADDRESS <i>W. Cook Inc 1217 St Paul St.</i>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01629

1649

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - State Line, Penna.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>75x-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Victor LARRICK, Sr.</u>		4. DATE OF DEATH Month Day Year <u>22 27 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/81</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Larrick</u>		14. MOTHER'S MAIDEN NAME <u>A. Cornelia Larrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>4-44</u>	
17. INFORMANT <u>Record, Springfield State Hospital, Sykesville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarctive myocardial fibrosis</u> DUE TO (c) <u>Coronary and generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc. with cerebral arteriosclerosis with psychotic reaction</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>56</u> , to <u>2/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/27</u> , 19 <u>56</u> , and that death occurred at <u>8:07 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sykesville, Maryland 2/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Near Leesport Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Coffman</u>		ADDRESS <u>Washington Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Ewer</u>	

(continued)

BUREAU V. S.

FEB 29 1956

RECEIVED

01630

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1650

FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH - COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>RAY - ELLWOOD - LEISTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 28 1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>May 5 - 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elect. Installation</u>	11. BIRTHPLACE (State or foreign country) <u>Ind</u>
13. FATHER'S NAME <u>Abraham Leister</u>		12. COUNTRY OF BIRTH <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-09-2753</u>	
17. INFORMANT AND ADDRESS <u>Muriel Leister, Hampstead Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Shot thru Wound of face head

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Depression

(c)

INTERVAL BETWEEN ONSET AND DEATH

Instantaneous27 x

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Peaced loaded 12 gauge shot gun to frontal region</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL - CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Reburied</u>	<u>Mar 7 - 1956</u>	<u>Manchester</u>	<u>Carroll Co Md</u>	
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/29/56</u>	<u>Henry Wells</u>	<u>Edna E. Sepland</u>	<u>Hampstead Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1956

BUREAU V. S.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lineboro</u>				TOWN <u>Lineboro, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lineboro, Md.</u>				STREET ADDRESS (If rural give location) <u>Lineboro, Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>Lichtfuss Sr.</u> (Last)				<u>Feb. 24/56</u> 19 <u>56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 20, 1901</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 Year		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Egidius Lichtfuss</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Md. Mrs Elizabeth Lichtfuss, Lineboro</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 <u>580X</u> IMMEDIATE CAUSE (A) <u>ACUTE Hepatitis Possible Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Peptic Uleers</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Histoplasmosis Lungs</u>						<u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11</u> <u>1953</u> , to <u>Feb 23</u> <u>1956</u> , that I last saw the deceased alive on <u>2/23/56</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. F. oard</u>				DATE SIGNED <u>2/23/56</u>			
ADDRESS (Street, city, town, state) <u>23 North Main St. Manchester Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 28/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
24. REC'D BY REGISTRAR <u>158 27 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. J. H. Denson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Witzke</u>		ADDRESS <u>101 Edmondson Ave</u>	

• • •

BUREAU V. S.

FE3 28 1356

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01632

1652 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN		Frizzelburg, Carroll Co.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Frizzelburg, Maryland		STREET ADDRESS		(If rural, give location)		Frizzelburg, Carroll Co. Md.	
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Lillie		M		Martin		Feb		8 19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year If under 24 hrs.	
Female	White	WIDOW		Apr 2, 1871		84 yrs.		10/ 6 Months/ Days/ Hours/ Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housework				Bachman Valley Carroll Co.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
David Palmer				Mary Weaver					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS			
						Mrs Wm Warner, Frizzelburg, Md			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592x Immediate cause (a).....		Myocardial (aort.) Hypertension (abn)			
Antecedent cause(s) (b).....		Hypertension			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from.....*May*....., 19*55* to.....*Feb 3*....., 19*56*, that I last saw the deceased alive on.....*2-7-56*....., and that death occurred at.....*3:30 P*.....m., from the causes and on the date stated above.

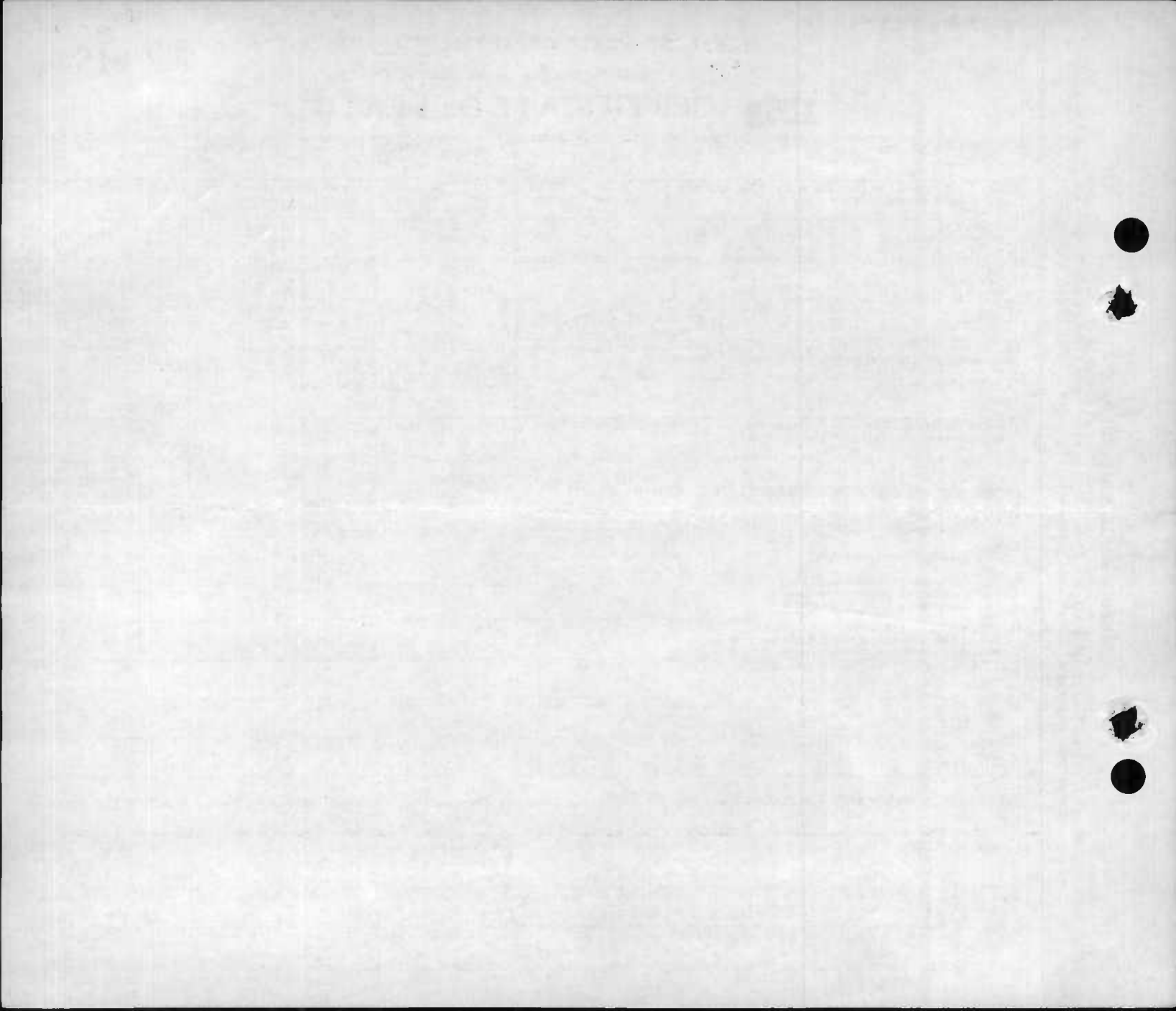
SIGNATURE.....*W. C. J. Smith*..... ADDRESS.....*Westminster Md.*..... DATE SIGNED.....*2-9-56*.....

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-12-56	Manchester Luthern Cem	Manchester, Maryland	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<i>Feb 10, 1956</i>	<i>A. W. Hedrick</i>	David R. Martin, 1902 Eutaw Place Baltimore, Md		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital. Attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01633

Item 2 from Crawford Retreat by phone 3-14-56 and

1653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) * Sykesville		c. LENGTH OF STAY IN 1b 4yrs. 24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital		d. STREET ADDRESS 3902 Southern Avenue 2117 Denison St. - Balto.	
3. NAME OF DECEASED (Type or print) First Lee Middle Dora Last McDonald		4. DATE OF DEATH Month 2 Day 23 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?/?/1868
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rixeyville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Lilly		14. MOTHER'S MAIDEN NAME Margaret Salome Minich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital records -		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31, 1952 , to February 22, 1956 , that I last saw the deceased alive on February 22, 1956 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morrell N. Mastin		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 2-23-56	
PHYSICIAN'S NAME (Type) Morrell N. Mastin, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 1 1956	
22c. NAME OF CEMETERY OR CREMATORY Melville		22d. LOCATION (City, town, or county) (State) ELKRIDGE Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Hickman & Son Co 4905 YORK Rd		24a. RECEIVED BY REGISTRAR DATE Feb. 23, 1956	
24b. REGISTRAR'S SIGNATURE C. Harry Myers			

CERTIFICATE OF DEATH

COUNTY OF <u>ALLEGANY</u> STATE OF <u>PENNSYLVANIA</u>		DECEASED <u>JOHN J. BROWN</u>	
DATE OF DEATH <u>1956 FEB 29</u> PLACE OF DEATH <u>HOME</u>		AGE <u>68</u> SEX <u>M</u>	
OCCASION OF DEATH <u>NATURAL</u> CAUSE OF DEATH <u>HEART DISEASE</u>		PLACE OF BIRTH <u>NEW YORK</u> DATE OF BIRTH <u>1956 FEB 29</u>	
SIGNATURE OF DECEASED <u>JOHN J. BROWN</u> SIGNATURE OF WITNESSES <u>JOHN J. BROWN</u>		SIGNATURE OF PHYSICIAN <u>JOHN J. BROWN</u> SIGNATURE OF CLERK <u>JOHN J. BROWN</u>	
SIGNATURE OF MINISTER <u>JOHN J. BROWN</u> SIGNATURE OF CORONER <u>JOHN J. BROWN</u>		SIGNATURE OF JURY <u>JOHN J. BROWN</u> SIGNATURE OF JUDGE <u>JOHN J. BROWN</u>	

BUREAU V. S.

FEB 29 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01634

1654

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>5 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>TRUMAN</u> <u>HALE</u> <u>MEREDITH</u>				<u>2</u> - <u>11</u> - <u>56</u> 19			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>2-23-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>THOMAS N. MEREDITH</u>				14. MOTHER'S MAIDEN NAME <u>MARY GRIFFITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>J. MELVIN MEREDITH</u> <u>WESTMINSTER MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Myocarditis (acute) Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May, 1944</u> , to <u>2-11-56</u> , that I last saw the deceased alive on <u>2-10-56</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. C. Jermolits MD.</u>		M.D. <u>103 E. Main Westminister Md</u>		DATE SIGNED <u>2-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-14-1956</u>		NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harold Muller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Bankard</u>		ADDRESS <u>P. 509 Westminister Md.</u>	
DATE <u>2-14-56</u>							

CERTIFICATE OF DEATH

1955

Page One

1. NAME OF DECEASED

LAST

FIRST

DATE OF DEATH

EXHIBITION

BUREAU V. S.

FEB 16 1955

RECEIVED

MARYLAND

01635
STATE DEPARTMENT OF HEALTH

1655 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>3101 Mary Avenue</u>	
3. NAME OF DECEASED (First) <u>Grace</u> (Middle) <u>Er--</u> (Last) <u>Miller</u>		4. DATE OF DEATH (Month) <u>2-</u> (Day) <u>8-</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-4-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blainey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
490X Immediate cause (a) <u>Lobar pneumonia</u>			24 hrs.
Antecedent cause(s) (b) <u>Cerebral arteriosclerosis</u>			10 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>-----</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>-----</u>	
SUICIDE <u>-----</u>		INJURY <u>-----</u>	
HOMICIDE <u>-----</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-----</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>-----</u>	

22. I hereby certify that I attended the deceased from 1-19-45, 19....., to 2-7-....., 1956....., that I last saw the deceasedalive on 2-7-....., 1956, and that death occurred at 3:00 A.m., from the causes and on the date stated above.SIGNATURE M. N. Mastin M.D. (Degree or title) ADDRESS Springfield State Hosp., Sykesville, Md. DATE SIGNED 2-8-56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb. 11/56</u>	<u>Druid Ridge Cemetery</u>	<u>Pikesville 8, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 10, 1956</u>	<u>A. W. Hedrick</u>	<u>Harry H. Witke</u>	<u>4101 EDMONDSON AVE.</u>

MARGIN RESERVED FOR BINDING

John

1656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>3 yrs +</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Springfield State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ELIZABETH REGINA</i> First Middle Last				4. DATE OF DEATH <i>February</i> Month Day Year <i>22 1956</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/16/184</i>	
9. AGE (In years last birthday) <i>71</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Matthew Sheehan</i>			
14. MOTHER'S MAIDEN NAME <i>Cather. McQuincy</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Hospital records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>331X</i> DUE TO <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>hours</i> <i>4 yrs plus</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senile psychosis paranoid type</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>4/9/1952</i> to <i>2/22/1956</i> , that I last saw the deceased alive on <i>2/22/1956</i> , and that death occurred at <i>2:17 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>SOMMERFELDT, Gertrude</i>				ADDRESS (Street, city or town, state) <i>Springfield State Hospital, Sykesville Md</i> DATE SIGNED <i>2-22-56</i>			
PHYSICIAN'S NAME (Type) <i>Gertrude Sommerfeldt M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Feb 25-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cn</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter B. M. Walter</i> ADDRESS <i>Pratt & Street</i>				24a. REC'D BY REGISTRAR <i>APR 23 1956</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1258

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>65</i>		4. RACE <i>WHITE</i>	
5. DATE OF DEATH <i>FEB 23 1956</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>HOME</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>	
9. DISEASE OR INJURY <i>MYOCARDIAL INFARCTION</i>		10. PERMANENT DAMAGE <i>NO</i>	
11. SIGNATURE OF PHYSICIAN <i>J. H. SMITH</i>		12. SIGNATURE OF REGISTRAR <i>J. H. SMITH</i>	
13. SIGNATURE OF WITNESSES <i>J. H. SMITH</i>		14. SIGNATURE OF DECEASED <i>J. H. SMITH</i>	
15. SIGNATURE OF FUNERAL HOME <i>J. H. SMITH</i>		16. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>	
17. SIGNATURE OF CEMETERY <i>J. H. SMITH</i>		18. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
19. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		20. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
21. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		22. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
23. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		24. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
25. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		26. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
27. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		28. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
29. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		30. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
31. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		32. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
33. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		34. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
35. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		36. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
37. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		38. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
39. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		40. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
41. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		42. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
43. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		44. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
45. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		46. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
47. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		48. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
49. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		50. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
51. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		52. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
53. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		54. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
55. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		56. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
57. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		58. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
59. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		60. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
61. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		62. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
63. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		64. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
65. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		66. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
67. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		68. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
69. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		70. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
71. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		72. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
73. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		74. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
75. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		76. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
77. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		78. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
79. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		80. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
81. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		82. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
83. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		84. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
85. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		86. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
87. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		88. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
89. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		90. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
91. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		92. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
93. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		94. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
95. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		96. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
97. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		98. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	
99. SIGNATURE OF BURIAL PLACE <i>J. H. SMITH</i>		100. SIGNATURE OF INTERMENT <i>J. H. SMITH</i>	

BUREAU V. S.

FEB 23 1956

RECEIVED

CERTIFICATE OF DEATH

Form 100-100

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWN CLERK

20. SIGNATURE OF VOTING CLERK

21. SIGNATURE OF POLLING CLERK

22. SIGNATURE OF TELLER

23. SIGNATURE OF CLERK

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF DISTRICT ATTORNEY

29. SIGNATURE OF COUNTY CLERK

30. SIGNATURE OF TOWN CLERK

31. SIGNATURE OF VOTING CLERK

32. SIGNATURE OF TELLER

33. SIGNATURE OF CLERK

34. SIGNATURE OF JURY

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CORONER

38. SIGNATURE OF DISTRICT ATTORNEY

39. SIGNATURE OF COUNTY CLERK

40. SIGNATURE OF TOWN CLERK

41. SIGNATURE OF VOTING CLERK

42. SIGNATURE OF TELLER

43. SIGNATURE OF CLERK

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CORONER

48. SIGNATURE OF DISTRICT ATTORNEY

49. SIGNATURE OF COUNTY CLERK

50. SIGNATURE OF TOWN CLERK

51. SIGNATURE OF VOTING CLERK

52. SIGNATURE OF TELLER

53. SIGNATURE OF CLERK

BUREAU V. S.

FEB 16 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01638

CERTIFICATE OF DEATH

1658

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>11 Y 20 days</u>		TOWN <u>Arbutus-27</u>		<u>03-51-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15 Springfield State Hospital</u>				<u>5234 Benson Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WALTER</u> (Middle) <u>RAYMOND</u> (Last) <u>PRICE</u>				(Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Div.</u>	<u>10/18/00</u>	<u>55</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>				<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ephriam Price</u>				<u>Katie Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>yes</u> (If Yes, give war or dates of service)		<u>13135888</u>		<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>1 years</u>			
IMMEDIATE CAUSE (A) <u>Carcinoma of bladder</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Brain Syndrome associated with drug intoxication (barbiturates?)</u>				<u>1 year?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/19</u> , 19 <u>55</u> , to <u>2/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/20/56</u>		<u>Baltimore National Cem. Baltimore, Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 20 1956</u>		<u>C. Harry Harris</u>		<u>Ambrose, Inc. 1328 Sulphur Sp. Rd.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

8/20/56
 Baltimore National Com. Baltimore, Md.
 Ambrose, Inc. 1328 Baltimore Sq. Rd.
 RECEIVED
 FEB 20 1956
 BUREAU A

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. PLACE OF DEATH [Faint text]		6. CAUSE OF DEATH [Faint text]	
7. MANNER OF DEATH [Faint text]		8. SIGNATURE OF PHYSICIAN [Faint text]		9. SIGNATURE OF REGISTRAR [Faint text]	
10. SIGNATURE OF WITNESS [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	

ENCLOSURE

1659 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u># 5</u>		STREET ADDRESS <u>R.D. 5</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FRANK BERTAM RICHARDS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 19 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 22, 1906</u>
9. AGE last birthday <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MR. HERBERT F. RICHARDS retired</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN MC DAVID</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Herbert F. Richards Westminster, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>910.1</u> Immediate cause (a) <u>Crushing injury to chest</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>farm</u> (CITY OR TOWN) <u>Westminster</u> (COUNTY) <u>Carroll</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 19 1956 99 m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Tree fell on him</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James V. Marsh</u>		DATE SIGNED <u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2-22-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>PRIDERS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
DATE REC'D BY LOCAL REG. <u>2-22-56</u>		24. FUNERAL DIRECTOR <u>Hansel Miller</u>	
REGISTRAR'S SIGNATURE <u>Hansel Miller</u>		ADDRESS <u>AT Bankard Ave Westminster, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 24 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01641

1617 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>56 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 UNION ST.</u>				STREET ADDRESS (If rural give location) <u>23 Union</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>LOTTIE VIRGINIA ROSS</u>				(Month) (Day) (Year) <u>2 8 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>5-25-1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN E. DIGGS</u>				14. MOTHER'S MAIDEN NAME <u>NORA E. DERRICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>LILLIAN ROSS WESTMINSTER MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cardiovascular Renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis & Hypertension</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Mild Diabetes & Gangrene Left</u>				<u>2 wks</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility great toe</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u>, 19<u>54</u>, to <u>Feb 8</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 7</u>, 19<u>56</u>, and that death occurred at <u>9:10 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>William Speicher</u>		ADDRESS (Street, city, town, state) <u>Westminster Md Feb 9/1956</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-13/1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. LUKE'S CEMETERY</u>		LOCATION (City, town, or county) (State) <u>NEISTEPSTOWN, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Muller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bankard</u>		ADDRESS <u>Hon Westminster, Md.</u>	
DATE <u>2-14-56</u>							

CERTIFICATE OF DEATH

MASS. REG. NO. 100

TO BE FILLED BY THE REGISTRAR OF DEATHS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		M		W		FEB 16 1956		BALTIMORE, MD.	
BIRTH		DATE		PLACE		CITY		STATE		COUNTRY	
JAN 15 1921		JAN 15 1921		BALTIMORE		MD.		MD.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY	
MAY 15 1945		MAY 15 1945		BALTIMORE		MD.		MD.		U.S.A.	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		FEB 16 1956		JAMES J. JONES	

BUREAU V. 3.

FEB 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01642

Item 12, Film G 193, 3/2/56 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 mo 29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Springfield State Hospital</u>				d. STREET ADDRESS <u>5004 Ready Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Johannes</u> Middle Last <u>Sacks</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1956</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-91</u>	9. AGE (In years last birthday) yrs. <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bill collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Sacks</u>				14. MOTHER'S MAIDEN NAME <u>Soldie Crocker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Embolism</u> <u>463x</u> DUE TO <u>Thrombophlebitis in both legs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 weeks</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoneurotic reaction reactive depression</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-17</u> , 19 <u>56</u> , to <u>2-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>56</u> , and that death occurred at <u>100p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Schmenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>2/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Schmenfeldt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bnei Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>				ADDRESS <u>2100 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>DATE 2-27-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>			

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01643

166 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>28 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2226 Callow Avenue, Zone 17.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ethel Carrie James Saucerman</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 31, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Helman James</u>				14. MOTHER'S MAIDEN NAME <u>Martha Scarber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>7426</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic Mitral heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adhesive pericarditis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Old healed pulmonary tuberculosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>4 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>2/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>56</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Jannendick</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Turner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Look Inc.</u>		ADDRESS <u>Balto. Md.</u>	

1662

CERTIFICATE OF DEATH

Reg. Dist. No.

01644

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield State Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident 11x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp. Sykesville, Md.		d. STREET ADDRESS Accident, Garrett Co. Md	
3. NAME OF DECEASED (Type or print) MARTHA E. SCHLOSNABLE		4. DATE OF DEATH 2 Month 29 Day 1956	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY SCHLOSNABLE	
14. MOTHER'S MAIDEN NAME ELINABETH STARK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Nellie F. Schosnagle 421 Raspe Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PELITIS. 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION, DIABETES MELLITUS, INVOLUTIONAL PSYCHOSIS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 1-29 1956 , to 2-24 1956 , that I last saw the deceased alive on 2-24 1956 , and that death occurred at 11:35 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Julian Radzykewicz M.D. SSH. PHYSICIAN'S NAME (Type) DR. JULIAN RADZYKEWYCZ			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/56	22c. NAME OF CEMETERY OR CREMATORY St Paul's Luth Cen.
22d. LOCATION (City, town, or county) _____ (State) _____		22e. REGISTRAR'S SIGNATURE Garrett Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lassalio Funeral Home 7401 Belair Rd		24. REC'D BY REGISTRAR FEB 27 1956	

CERTIFICATE OF DEATH

1505

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15

See Back

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>Massachusetts</i></p>	
<p>5. Date of death: <i>Feb 27, 1956</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of registration: <i>Feb 27, 1956</i></p>		<p>12. Office of registration: <i>Boston</i></p>	

FEB 27 1956

BUREAU V. 8

RECEIVED

1618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>50 yrs</u>				d. STREET ADDRESS <u>31 Carroll St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 Carroll St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GIRARD SCHWINN</u>				4. DATE OF DEATH Month Day Year <u>Feb. 27 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1887</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk in Bowling alley</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Henry Schwinn</u>				14. MOTHER'S MAIDEN NAME <u>Lena?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>214-01-0488</u>		17. INFORMANT Address <u>Mrs. Wm. H. Schwinn, Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-renal Vascular Disease</u> DUE TO (c) <u>3 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2-24-56</u> to <u>2-27-56</u> , that I last saw the deceased alive on <u>2-27-56</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. R. Fouts</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>2-27-56</u>			
PHYSICIAN'S NAME (Type) <u>CHAS. R. FOUTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 29, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery Rural, Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminster Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>3-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Criller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1018

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

MAR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELLEN SHERFEY</u>				4. DATE OF DEATH Month Day Year <u>FEB 29 1956</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK T LAMBERT</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET METZ</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>P.M. SHERFEY NEW WINDSOR, MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging by the neck</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self from cellar ceiling</u>							
20c. TIME OF INJURY Month, Day, Year <u>10 a.m. 2/29 1956</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>New Windsor Carroll Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>James J. Marsh</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>3/1/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3/3/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>PIPECREEK CEM.</u>				22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. HARTIGER & SONS</u>						ADDRESS <u>NEW WINDSOR, MD</u>		24a. REC'D BY REGISTRAR <u>March 2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Ernest B. Benedict</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - LANSING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

RECEIVED
MAR 5 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1619 CERTIFICATE OF DEATH

01647

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
27 TOWN Westminster		6 years		27 TOWN Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 46 W. Chase Street				STREET ADDRESS (If rural give location) 46 W. Chase Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) Walter Jacob Silverberg				Feb. 23 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Sept. 23, 1876	79	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired		Theatre Owner		Germany		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Silverberg				Goldie Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Md. Mrs. Goldie Silverberg Westminster			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				White Cerebral Hemorrhage 15 minutes			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Ch. Myocarditis + Anterophloia 15 years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 23, 19 56, to Feb 23, 19 56, that I last saw the deceased alive on Feb 23, 19 56, and that death occurred at 12:30 P.M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Reuther Ben M.D. Westminster Maryland				3/23/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		2-27-56		Loudon Park Cemetery		Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE 2-28-56		Harriet Mullen		Lewis 2100 Eutaw Pl			

JK

BUREAU V. S.

MAR 1 1956

RECEIVED

John Smith 5025-5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1665 CERTIFICATE OF DEATH

01649

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>since 8/19/42</u>		TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3608 Old Frederick Road.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joseph</u> <u>---</u> <u>STEIGER</u>				<u>February 17</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>single</u>	<u>March 17, 1923</u>	<u>32</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>---</u>		<u>Maryland</u>		<u>United States</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Steiger</u>				<u>Helen Bougnet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Catatonic stupor</u>						<u>more than 10 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Catatonic schizophrenia</u>						<u>more than 15 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Acute meningitis found on autopsy. Organism not yet determined</u>						<u>2-3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>2</u>		<u>---</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>---</u>		<u>---</u>		<u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>---</u>		<u>M. <input type="checkbox"/> at work <input type="checkbox"/></u>		<u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 1st, 1947</u> , to <u>Feb. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>56</u> , and that death occurred at <u>5:00A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>2/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-20-56</u>		<u>NEW CATHEDRAL</u>		<u>BALTIMORE Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 20 1956</u>		<u>C. Harry Davis</u>		<u>George L. Schwalb</u>		<u>Baltimore Md.</u>	

CERTIFICATE OF DEATH

Form 100-10-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL SOCIETY

17. SIGNATURE OF INTERMENT SOCIETY

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF MINISTRY

21. SIGNATURE OF CLERGY

22. SIGNATURE OF RABBI

23. SIGNATURE OF MINISTER

24. SIGNATURE OF PASTOR

25. SIGNATURE OF CHAPLAIN

26. SIGNATURE OF DEACON

27. SIGNATURE OF ELDER

28. SIGNATURE OF MODERATOR

29. SIGNATURE OF CLERK

30. SIGNATURE OF TREASURER

31. SIGNATURE OF SECRETARY

32. SIGNATURE OF ASSISTANT SECRETARY

33. SIGNATURE OF CHIEF CLERK

34. SIGNATURE OF CHIEF CLERK

35. SIGNATURE OF CHIEF CLERK

36. SIGNATURE OF CHIEF CLERK

37. SIGNATURE OF CHIEF CLERK

38. SIGNATURE OF CHIEF CLERK

39. SIGNATURE OF CHIEF CLERK

40. SIGNATURE OF CHIEF CLERK

41. SIGNATURE OF CHIEF CLERK

42. SIGNATURE OF CHIEF CLERK

43. SIGNATURE OF CHIEF CLERK

44. SIGNATURE OF CHIEF CLERK

45. SIGNATURE OF CHIEF CLERK

46. SIGNATURE OF CHIEF CLERK

47. SIGNATURE OF CHIEF CLERK

48. SIGNATURE OF CHIEF CLERK

49. SIGNATURE OF CHIEF CLERK

50. SIGNATURE OF CHIEF CLERK

51. SIGNATURE OF CHIEF CLERK

52. SIGNATURE OF CHIEF CLERK

53. SIGNATURE OF CHIEF CLERK

54. SIGNATURE OF CHIEF CLERK

55. SIGNATURE OF CHIEF CLERK

56. SIGNATURE OF CHIEF CLERK

57. SIGNATURE OF CHIEF CLERK

58. SIGNATURE OF CHIEF CLERK

59. SIGNATURE OF CHIEF CLERK

60. SIGNATURE OF CHIEF CLERK

61. SIGNATURE OF CHIEF CLERK

62. SIGNATURE OF CHIEF CLERK

63. SIGNATURE OF CHIEF CLERK

64. SIGNATURE OF CHIEF CLERK

65. SIGNATURE OF CHIEF CLERK

66. SIGNATURE OF CHIEF CLERK

67. SIGNATURE OF CHIEF CLERK

68. SIGNATURE OF CHIEF CLERK

69. SIGNATURE OF CHIEF CLERK

70. SIGNATURE OF CHIEF CLERK

71. SIGNATURE OF CHIEF CLERK

72. SIGNATURE OF CHIEF CLERK

73. SIGNATURE OF CHIEF CLERK

74. SIGNATURE OF CHIEF CLERK

75. SIGNATURE OF CHIEF CLERK

76. SIGNATURE OF CHIEF CLERK

77. SIGNATURE OF CHIEF CLERK

78. SIGNATURE OF CHIEF CLERK

79. SIGNATURE OF CHIEF CLERK

80. SIGNATURE OF CHIEF CLERK

81. SIGNATURE OF CHIEF CLERK

82. SIGNATURE OF CHIEF CLERK

83. SIGNATURE OF CHIEF CLERK

84. SIGNATURE OF CHIEF CLERK

85. SIGNATURE OF CHIEF CLERK

86. SIGNATURE OF CHIEF CLERK

87. SIGNATURE OF CHIEF CLERK

88. SIGNATURE OF CHIEF CLERK

89. SIGNATURE OF CHIEF CLERK

90. SIGNATURE OF CHIEF CLERK

BUREAU Y. B.

FEB 20 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01650

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Henryton, Maryland</u>	LENGTH OF STAY (In this place) <u>7 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>03 Henryton State Hospital</u>		STREET ADDRESS (If rural give location) <u>926 Madison Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Andrew Stevenson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 27 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-21-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Cypress Chapel, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jim Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Beasley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-07-8472</u>	
17. INFORMANT & ADDRESS <u>Eva Queen - 926 Madison Avenue</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X IMMEDIATE CAUSE (A) Far Advanced pulmonary tuberculosis</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cancer of the Prostate</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-20-</u> , 19 <u>56</u> , to <u>2-27-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-27-</u> , 19 <u>56</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>T. F. Vesal</u> M.D. <u>Henryton, Maryland</u> ADDRESS (Street, city, town, state) DATE SIGNED <u>2-27-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Albert R. Swankhaus</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>E. O. Wilson</u>		ADDRESS <u>1000 Brantley Ave.</u>	
DATE <u>2-27-56</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

01000

Form No. 10

1. USUAL RESIDENCE OF DECEASED

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

STREET ADDRESS

APARTMENT NO.

ZIP CODE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

BUREAU V. E.

FEB 29 1956

RECEIVED

NOTIFICATION

2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1667 CERTIFICATE OF DEATH

01651

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Finksburg Rural</u>		<u>4 yrs</u>		TOWN <u>Taneytown Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Philip</u>		(Middle) <u>B</u>		(Last) <u>Stuller</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 27, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>canning factory</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Stuller</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Koontz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-0220</u>		17. INFORMANT & ADDRESS <u>Mrs. Georgiett Hale, Finksburg, R# 1</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>myocarditis - chronic</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension - general</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis</u>						<u>2 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-</u> <u>53</u> to <u>2-18-</u> <u>56</u> , that I last saw the deceased alive on <u>2-16-56</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John G. Sappell</u>		M.D. <u>Reisterstown Md</u>		DATE SIGNED <u>2-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Feb. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Reformed Church</u>		LOCATION (City, town, or county) (State) <u>Laneytown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Herman Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		ADDRESS <u>Laneytown Md</u>	
DATE <u>2-21-56</u>							

CERTIFICATE OF DEATH

For Use by

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

BUREAU V. S.

FEB 24 1956

RECEIVED

26. SIGNATURE OF DECEASED

27. SIGNATURE OF DECEASED

28. SIGNATURE OF DECEASED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01652

1668 **CERTIFICATE OF DEATH**Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>4 mos. 23 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		<u>15-56-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>4110 Dayton Street, Silver Spring</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>SUMMERS</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/7/68</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>telephone company</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular disease</u>						<u>years</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Uremia due to chronic nephritis</u>						<u>years</u>	
4. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with cerebral arteriosclerosis, with otitis</u>						<u>18 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>psychosis</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/17/56</u> , 19 <u>56</u> , to <u>2/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>56</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sommers</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>2-2-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. & H. Hines Co.</u>		ADDRESS <u>2901-14th St. NW</u>	

41055

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

1968

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. AGE

13. OCCUPATION

14. CAUSE OF DEATH

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX

20. AGE

21. OCCUPATION

22. CAUSE OF DEATH

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX

28. AGE

29. OCCUPATION

30. CAUSE OF DEATH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. AGE

37. OCCUPATION

38. CAUSE OF DEATH

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX

44. AGE

45. OCCUPATION

46. CAUSE OF DEATH

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX

52. AGE

53. OCCUPATION

54. CAUSE OF DEATH

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. AGE

61. OCCUPATION

62. CAUSE OF DEATH

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. SEX

68. AGE

69. OCCUPATION

70. CAUSE OF DEATH

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX

76. AGE

77. OCCUPATION

78. CAUSE OF DEATH

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX

84. AGE

85. OCCUPATION

86. CAUSE OF DEATH

87. DATE OF DEATH

88. TIME OF DEATH

89. PLACE OF BIRTH

90. DATE OF BIRTH

91. SEX

92. AGE

93. OCCUPATION

94. CAUSE OF DEATH

95. DATE OF DEATH

96. TIME OF DEATH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. SEX

100. AGE

101. OCCUPATION

102. CAUSE OF DEATH

103. DATE OF DEATH

104. TIME OF DEATH

105. PLACE OF BIRTH

106. DATE OF BIRTH

107. SEX

108. AGE

109. OCCUPATION

110. CAUSE OF DEATH

111. DATE OF DEATH

112. TIME OF DEATH

113. PLACE OF BIRTH

114. DATE OF BIRTH

115. SEX

116. AGE

117. OCCUPATION

118. CAUSE OF DEATH

119. DATE OF DEATH

120. TIME OF DEATH

121. PLACE OF BIRTH

122. DATE OF BIRTH

123. SEX

124. AGE

125. OCCUPATION

126. CAUSE OF DEATH

127. DATE OF DEATH

128. TIME OF DEATH

129. PLACE OF BIRTH

130. DATE OF BIRTH

131. SEX

132. AGE

133. OCCUPATION

134. CAUSE OF DEATH

135. DATE OF DEATH

136. TIME OF DEATH

137. PLACE OF BIRTH

138. DATE OF BIRTH

139. SEX

140. AGE

141. OCCUPATION

142. CAUSE OF DEATH

143. DATE OF DEATH

144. TIME OF DEATH

145. PLACE OF BIRTH

146. DATE OF BIRTH

147. SEX

148. AGE

149. OCCUPATION

150. CAUSE OF DEATH

151. DATE OF DEATH

152. TIME OF DEATH

153. PLACE OF BIRTH

154. DATE OF BIRTH

155. SEX

156. AGE

157. OCCUPATION

158. CAUSE OF DEATH

159. DATE OF DEATH

160. TIME OF DEATH

161. PLACE OF BIRTH

162. DATE OF BIRTH

163. SEX

164. AGE

165. OCCUPATION

166. CAUSE OF DEATH

167. DATE OF DEATH

168. TIME OF DEATH

169. PLACE OF BIRTH

170. DATE OF BIRTH

171. SEX

172. AGE

173. OCCUPATION

174. CAUSE OF DEATH

175. DATE OF DEATH

176. TIME OF DEATH

177. PLACE OF BIRTH

178. DATE OF BIRTH

179. SEX

180. AGE

181. OCCUPATION

182. CAUSE OF DEATH

183. DATE OF DEATH

184. TIME OF DEATH

185. PLACE OF BIRTH

186. DATE OF BIRTH

187. SEX

188. AGE

189. OCCUPATION

190. CAUSE OF DEATH

191. DATE OF DEATH

192. TIME OF DEATH

193. PLACE OF BIRTH

194. DATE OF BIRTH

195. SEX

196. AGE

197. OCCUPATION

198. CAUSE OF DEATH

199. DATE OF DEATH

200. TIME OF DEATH

201. PLACE OF BIRTH

202. DATE OF BIRTH

203. SEX

204. AGE

205. OCCUPATION

206. CAUSE OF DEATH

207. DATE OF DEATH

208. TIME OF DEATH

209. PLACE OF BIRTH

210. DATE OF BIRTH

211. SEX

212. AGE

213. OCCUPATION

214. CAUSE OF DEATH

215. DATE OF DEATH

216. TIME OF DEATH

217. PLACE OF BIRTH

218. DATE OF BIRTH

219. SEX

220. AGE

221. OCCUPATION

222. CAUSE OF DEATH

223. DATE OF DEATH

224. TIME OF DEATH

225. PLACE OF BIRTH

226. DATE OF BIRTH

227. SEX

228. AGE

229. OCCUPATION

230. CAUSE OF DEATH

231. DATE OF DEATH

232. TIME OF DEATH

233. PLACE OF BIRTH

234. DATE OF BIRTH

235. SEX

236. AGE

237. OCCUPATION

238. CAUSE OF DEATH

239. DATE OF DEATH

240. TIME OF DEATH

241. PLACE OF BIRTH

242. DATE OF BIRTH

243. SEX

244. AGE

245. OCCUPATION

246. CAUSE OF DEATH

247. DATE OF DEATH

248. TIME OF DEATH

249. PLACE OF BIRTH

250. DATE OF BIRTH

251. SEX

252. AGE

253. OCCUPATION

254. CAUSE OF DEATH

255. DATE OF DEATH

256. TIME OF DEATH

257. PLACE OF BIRTH

258. DATE OF BIRTH

259. SEX

260. AGE

261. OCCUPATION

262. CAUSE OF DEATH

263. DATE OF DEATH

264. TIME OF DEATH

265. PLACE OF BIRTH

266. DATE OF BIRTH

267. SEX

268. AGE

269. OCCUPATION

270. CAUSE OF DEATH

271. DATE OF DEATH

272. TIME OF DEATH

273. PLACE OF BIRTH

274. DATE OF BIRTH

275. SEX

276. AGE

277. OCCUPATION

278. CAUSE OF DEATH

279. DATE OF DEATH

280. TIME OF DEATH

281. PLACE OF BIRTH

282. DATE OF BIRTH

283. SEX

284. AGE

285. OCCUPATION

286. CAUSE OF DEATH

287. DATE OF DEATH

288. TIME OF DEATH

289. PLACE OF BIRTH

290. DATE OF BIRTH

291. SEX

292. AGE

293. OCCUPATION

294. CAUSE OF DEATH

295. DATE OF DEATH

296. TIME OF DEATH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01653

1669

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY _____	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>30 months</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2625 Robb St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>John Frederick Treulieb</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>11-9-69</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>upsh</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Treulieb-unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown Mary Kemp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes 9-23-91 to 3-30-92</u>		16. SOCIAL SECURITY NO. <u>????</u>		17. INFORMANT & ADDRESS <u>records of Springfield State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Renal failure due to severe nephrosclerosis</u>						<u>years</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease vascular disease</u>						<u>years</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Edema</u>						<u>few days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile brain syndrome with psychotic reaction</u>						<u>4 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4</u> , 19 <u>53</u> , to <u>Feb. 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 7</u> , 19 <u>56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md</u>		DATE SIGNED <u>2-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #14</u>			

CERTIFICATE OF DEATH

Best One

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF DEITY

25. SIGNATURE OF HEAVEN

FEB 14 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01654

1670

CERTIFICATE OF DEATH

Reg. Dist. No. 81

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>UNION BRIDGE</u>		<u>YEARS</u>		TOWN <u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>LIGHTNER ST</u>				<u>LIGHTNER ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MINNIE NOKES WALKER</u>				<u>FEB 8 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>FEMALE</u>		<u>COLORED</u>		<u>WIDOW</u>		<u>MAY 28-1887</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>68 yrs.</u>		<u>HOUSE KEEPER</u>		<u>AT HOME</u>		<u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U.S.</u>				<u>THOMAS NOKES</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>CAROLINE ALLEN</u>				<u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>IVONE</u>				<u>AL. NOKES UNION BRIDGE MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 WEEK</u>	
<u>331X</u> IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 1</u>, 19<u>56</u>, to <u>FEB 8</u>, 19<u>56</u>, that I last saw the deceased alive on <u>FEB 7</u>, 19<u>56</u>, and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Mason</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>M.D. UNION BRIDGE, MD</u>		<u>FEB 9 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/11/56</u>		<u>MT JOY CEMETERY</u>		<u>UNIONTOWN, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 10, 1956</u>		<u>Philip J. Webb</u>		<u>D.D. HARTZLER & SONS</u>		<u>UNION BRIDGE MD</u>	

[illegible]

BUREAU A

FEB 14 1966

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01655

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Rural - Sykesville</u>		<u>2 Mos. 7 days</u>		TOWN <u>Baltimore</u>		<u>3 Yr 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1208 Brentwood Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CHARLES EDWARD WARNER, JR.</u>				<u>2 3 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>8/24/92</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>plumber</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Charles Edward Warner, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Craton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>4/17/17 - Army</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Septicemia</u>						<u>9 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bilateral Pyelonephritis</u>						<u>2 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General paresis; bronchopneumonia</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS associated with meningoencephalitis with psychotic reaction</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/25</u> , 19 <u>56</u> , to <u>2/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>56</u> , and that death occurred at <u>4:00PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sommerfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO. CITY</u>	
24. REC'D BY REGISTRAR <u>Feb. 7, 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Myers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WIEDEFELD & SON</u>		ADDRESS <u>GREENMOUNT AVE & 22ND</u>	

CERTIFICATE OF DEATH

Form 100-1-10

1. PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. TIME OF BIRTH

7. PLACE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. TIME OF BIRTH

13. PLACE OF DEATH

14. DATE OF DEATH

15. TIME OF DEATH

16. PLACE OF BIRTH

17. DATE OF BIRTH

18. TIME OF BIRTH

19. PLACE OF DEATH

20. DATE OF DEATH

21. TIME OF DEATH

22. PLACE OF BIRTH

23. DATE OF BIRTH

24. TIME OF BIRTH

25. PLACE OF DEATH

26. DATE OF DEATH

27. TIME OF DEATH

28. PLACE OF BIRTH

29. DATE OF BIRTH

30. TIME OF BIRTH

31. PLACE OF DEATH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF BIRTH

35. DATE OF BIRTH

36. TIME OF BIRTH

37. PLACE OF DEATH

38. DATE OF DEATH

39. TIME OF DEATH

40. PLACE OF BIRTH

41. DATE OF BIRTH

42. TIME OF BIRTH

43. PLACE OF DEATH

44. DATE OF DEATH

45. TIME OF DEATH

46. PLACE OF BIRTH

47. DATE OF BIRTH

48. TIME OF BIRTH

49. PLACE OF DEATH

50. DATE OF DEATH

51. TIME OF DEATH

52. PLACE OF BIRTH

53. DATE OF BIRTH

54. TIME OF BIRTH

BUREAU V. S.

FEB 8 1932

RECEIVED

2-10-32

RECEIVED
FEB 8 1932
BUREAU V. S.

1672

01656

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CARROLL	MARYLAND	STATE Maryland	COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Rural - Sykesville	LENGTH OF STAY (to this place) 5 days	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Union Bridge	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL		STREET ADDRESS (If rural, give location) Union St.	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) NANNIE (Middle) E. (Last) WHITEHILL		(Month) 2 (Day) 10 (Year) 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 1882
9. AGE last birthday: 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Home - housewife	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James C. Whitehill		14. MOTHER'S MAIDEN NAME: Sarah Sappington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: none	
17. INFORMANT & ADDRESS: Record, Springfield State Hospital			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
(a) Hemorrhage of the brain Immediate cause DUE TO		5 days?
(b) Fracture of the right temporal bone Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO Burns of face and neck and scalp		5 days? 5 days
(c) Uremia and shock due to burns		5 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychosis		months
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) (County) (State) Union Bridge Carroll Maryland
21d. TIME (Month) (Day) (Year) (Hour) 06 INJURY 2 5 56 ? M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Pt. poured kerosene on fire - exploded
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE James J. Morah		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 2/10/56
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF 2/13/56	NAME OF CEMETERY OR CREMATORY St. Peter's Cem.
LOCATION (City, town, or county) (State) Libertytown, Md.	24. FUNERAL DIRECTOR W. D. Harkley & Sons	ADDRESS Union Bridge, Md.
DATE REC'D BY LOCAL REG. Feb. 12, 1956	REGISTRAR'S SIGNATURE C. Harry Zelen	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 15 1956

RECEIVED

1673

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		Maryland		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Detour</i>		LENGTH OF STAY (in this place) <i>4 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Detour</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>FANNIE Wolfe</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 1 1956</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>9/2/1898</i>	9. AGE last birthday <i>57</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<i>housekeeper</i>			<i>at home</i>		<i>Marysville, Md</i>		<i>U.S.</i>
13. FATHER'S NAME: <i>Thomas L. Winfield</i>				14. MOTHER'S MAIDEN NAME: <i>Ellen King</i>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>C.H. Wolfe, Detour, Md.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE			(A) <i>Cerebral Thrombosis</i>				<i>1 day.</i>
ANTECEDENT CAUSE (S)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) <i>—</i>				
(C) <i>—</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>none</i>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i>			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Feb. 1</i> , 1956, to <i>Feb. 1</i> , 1956, that I last saw the deceased alive on <i>Feb. 1</i> , 1956, and that death occurred at <i>2 P. M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>James T. Gray</i>			M. D. <i>Thurmont Md.</i>		DATE SIGNED <i>2-1-56</i>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
<i>Burial</i>			<i>2/4/56</i>		<i>Beaver Dam Cw.</i>		<i>Frederick County, Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>3/56</i>			REGISTRAR'S SIGNATURE <i>Ethel M. Mehring</i>		24. FUNERAL DIRECTOR ADDRESS <i>Wm. H. Hartley & Sons Union Bridge</i>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 8 1956

BUREAU V. S.

1674 CERTIFICATE OF DEATH

8434 Ga. Ave.
ver Spring, Md.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. USUAL RESIDENCE (Write on reverse)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

20. SIGNATURE OF NOTARY

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF CONSTABLE

24. SIGNATURE OF JAILER

BUREAU V. S.

FEB 8 1935

RECEIVED

INSTRUCTIONS

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or jury, or by the registrar, or by the funeral home, or by the burial place, or by the interviewer, or by the coroner, or by the judge, or by the clerk, or by the notary, or by the sheriff, or by the deputy sheriff, or by the constable, or by the jailer.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1675 CERTIFICATE OF DEATH

01659

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Henryton, Maryland</u>		<u>718 days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>2403 W. Lafayette Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Barbara Wright</u>				<u>2 17 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>3-12-1925</u>	<u>30</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Meade Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Annie Lettley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mary Barbara Wright - 2403 W. Lafayette</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Profuse hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Far advanced cavitary pulmonary tuberculosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>3-1-</u> , 19 <u>54</u> , to <u>2-17-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17-</u> , 19 <u>56</u> , and that death occurred at <u>5:15AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>T.F. Westal</u>				ADDRESS (Street, city, town, state) <u>Henryton State Hospital</u>		DATE SIGNED <u>2-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Albert R. Swantham</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Deborah L Brown Son</u>		ADDRESS <u>108W Montg Omery St</u>	
DATE <u>2-17-56</u>							

1956 CERTIFICATE OF DEATH

Form No. 10-56

1. USUAL RESIDENCE OF DECEASED

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEXT OF KIN

22. SIGNATURE OF CLERGYMAN

23. SIGNATURE OF BURIAL OFFICIAL

24. SIGNATURE OF FUNERAL HOME

25. SIGNATURE OF CEMETERY

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF DECEASED

28. SIGNATURE OF NEXT OF KIN

29. SIGNATURE OF CLERGYMAN

30. SIGNATURE OF BURIAL OFFICIAL

BUREAU OF
FEB 20 1956

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1676 CERTIFICATE OF DEATH

01660

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural - Sykesville</u>		<u>since 4/30/52</u>		TOWN <u>Baltimore City</u>		<u>3801-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>402 N. Robinson</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>William</u> <u>Frederick</u> <u>ZIMMERMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>14</u> <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>September 20, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Stengel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>540.0 Hemorrhage due to peptic ulcer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction</u>	
19a. DATE OF OPERATION <u>2/13/56</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15</u> , 19 <u>52</u> , to <u>2/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>56</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeld</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>2/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
24. REC'D BY REGISTRAR <u>2-17-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Weber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF TOWNSHIP CLERK

17. SIGNATURE OF COUNTY CLERK

18. SIGNATURE OF STATE CLERK

19. SIGNATURE OF VICE CLERK

20. SIGNATURE OF DEPUTY CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF CLERK

23. SIGNATURE OF CLERK

24. SIGNATURE OF CLERK

25. SIGNATURE OF CLERK

26. SIGNATURE OF CLERK

27. SIGNATURE OF CLERK

28. SIGNATURE OF CLERK

BUREAU V. 1

FEB 23 1956

RECEIVED